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No. 88-2043

In The Supreme Court of the United States

OCTOBER TERM, 1989

GERALD L. BALILES,
et al.

Petitioners,

v.

THE VIRGINIA HOSPITAL ASSOCIATION

Respondent.

BRIEF AMICUS CURIAE OF TEMPLE UNIVERSITY— OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION IN SUPPORT OF THE RESPONDENT.

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20 pp

QUESTION PRESENTED

Whether a Medicaid provider has a private federal cause of action under 42 U.S.C. § 1983 to enforce the Medicaid Act against a State.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

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INTEREST OF AMICUS CURIAE

Amicus Temple University—Of the Commonwealth System of Higher Education ("Temple")[1] operates Temple University Hospital and is the largest provider of inpatient hospital care under the Pennsylvania Medicaid program. Temple is the plaintiff in an action challenging the compliance of Pennsylvania's Medicaid rate system with the federal Medicaid statute. *Temple Uni-*

[1]Temple is a Pennsylvania non-profit corporation which has been legislatively designated as state-related but which operates independently of state government under the direction of its board of trustees. 24 Pa. Cons. Stat. Ann. §§ 2510-1 *et seq.* (Purdon Supp. 1989).

versity—Of the Commonwealth System of Higher Education v. White, et al., Civ. No. 88-6646 (E.D. Pa.)

This amicus brief will not discuss the legal precedents applicable to this matter but rather describe the situation of inner city hospitals and the effect this Court's decision will have on them and the indigent communities they serve.

Temple University Hospital is the primary hospital for Temple's School of Medicine and provides a training ground for students, residents and fellows and a range of tertiary care to patients who are drawn to the hospital by the excellent reputation of its faculty physicians. Temple University Hospital also serves an area of North Philadelphia with a substantial indigent population which is largely black and Hispanic. The last census revealed that the neighborhoods around Temple University Hospital have poverty rates of between twenty-four percent and fifty-one percent. The residents of these neighborhoods have many and critical needs for medical services. For example, the infant mortality rate in these neighborhoods is among the highest in the United States, more than twice the national average. Seventy-two percent of the women giving birth are unmarried. Twenty percent of the babies born at Temple University Hospital are cocaine-addicted at birth and sixty percent suffer from low birth weight or other problems. An increasing percentage of newborns has syphilis or gonorrhea. Temple University Hospital provides the sophisticated obstetrical and neonatal care that these patients require.

About half of the inpatient admissions at Temple University Hospital are eligible for Medicaid, another

twenty percent (also largely indigent) are covered by Medicare and five percent have no source of payment at all. The Temple University Hospital emergency room acts as the family physician for thousands of indigents because of the shortage of physicians in the surrounding neighborhoods. Temple University Hospital is heavily dependent on the adequacy of Medicaid payments.[2]

Temple University Hospital is also in serious financial difficulty. It expects to lose about $15 million during its current fiscal year. Of this amount, at least $12 million will be as the result of care provided to medical assistance inpatients.[3] The remainder of the loss will result from treating Medicaid assistance outpatients and treating indigent inpatients and outpatients who do not qualify for Medicaid but cannot afford hospital care.

Congress has found that hospitals that serve large numbers of indigent patients usually have higher costs. Statistical studies offered by Temple at trial support this conclusion. Notwithstanding the fact that Temple

[2]Congress was concerned about the hospitals like Temple University Hospital: "The conferees recognize that public hospitals and teaching hospitals which serve a large Medicaid and low income population are particularly dependent on Medicaid reimbursement and are concerned that a State take into account the special situation that exists in these institutions in developing their rates." H.R. Conf. Rep. No. 208, 97th Cong., 1st Sess. at 962, *reprinted in* 1981 U.S. Code Cong. & Ad. News 1324.

[3]Pennsylvania pays for inpatient care by classifying the 229 general hospitals in the Commonwealth into seven groups and paying all hospitals in each group at the same rate. That rate is, by the Commonwealth's calculation, 14% below the average cost per case of the hospitals in each group. Temple University Hospital's group includes not only the six Philadelphia medical school hospitals, but Pittsburgh hospitals, Philadelphia hospitals affiliated with medical schools, Philadelphia community hospitals, Philadelphia suburban hospitals and two rural teaching hospitals. Thus, although Temple University Hospital is the average cost hospital in this diverse group, it is paid substantially less than its costs.

University Hospital has the largest number and percentage of Medicaid patients of the six medical school hospitals in Philadelphia,[4] it is, by ten percent, the least expensive of those hospitals. Temple University Hospital has achieved this position by cutting its costs substantially in recent years. It cannot continue to reduce costs without adversely affecting the quality or scope of care.[5]

To survive, Temple University Hospital needs additional revenue. Because Pennsylvania's Medicaid payments do not comply with the federal Medicaid statute, Temple filed an action in federal court in August of 1988 seeking injunctive relief against the officials responsible for the Pennsylvania Medicaid program. Temple's action is a systemic challenge which, if successful, would benefit all hospitals in the Commonwealth. Temple maintains that Pennsylvania's rates for inpatient hospital care violate federal law because they are not "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" and do not adequately "take into account the situation of hospitals which serve a disproportionate

[4]Temple's choice of hospitals with which to compare itself is consistent with Congressional recognition "that facilities that provide teaching services or other specialized tertiary care services . . may have operating costs which exceed those of a community hospital." H.R. Rep. No. 158, 97th Cong., 1st Sess., Vol II at 294 (1981).

[5]The ability of an inner city hospital to cut costs is limited by many factors, including the need to comply with national accreditation standards and comprehensive state regulations, the need to offer better than competitive salaries to persuade personnel to work in the inner city, the need for additional security and parking, the need to offer high quality services to attract higher paying patients to offset losses from Medicaid patients, and the need to provide the extra services required by indigent patients.

number of low income patients with special needs." 42 U.S.C. §§ 1396a(a)(13)(A) (1982 & Supp. V 1987), 42 U.S.C.A. § 1396r-4 (West Supp. 1989).

Temple's principal claims are the following:

1. Pennsylvania has established payment rates for inpatient hospital care without any reasoned analysis of the costs of economically and efficiently operated hospital. Rather, the level of the rates has been dictated annually by the Governor's Budget Secretary as that necessary to achieve the Governor's budgetary objectives.

2. Pennsylvania rates are sufficient to pay the costs of only about seventeen percent of the hospitals in the Commonwealth. The payments to those Philadelphia medical school hospitals that provide the largest volume of indigent care are not high enough to meet costs, no matter how efficiently those hospitals operate.

3. Pennsylvania has responded to the 1987 Congressional directive to make additional payments to those hospitals which serve a "disproportionate number of low income patients" by making the smallest additional payments that it thought it could get away with. Pennsylvania has made no reasoned analysis of the additional costs of the hospitals receiving those payments.

Temple's action was tried in June of 1989 and is awaiting decision. Temple's action may depend on this Court's resolution of this matter.[6]

[6]Temple's complaint also alleges jurisdiction under 28 U.S.C. § 1331 (1982), which jurisdiction is not directly before this Court. Temple's complaint also alleges that Medicaid rates do not adequately take into account the situation of "disproportionate share" hospitals (42 U.S.C. § 1396a(a)(13)(A) (1982 & Supp. V 1987), a claim not made by respondent Virginia Hospital Association.

SUMMARY OF ARGUMENT

In many states, the burden of providing the major portion of the medical care to Medicaid recipients falls heavily on a small number of inner city hospitals. Medicaid recipients are heavily dependent on these hospitals for their care and the hospitals, in turn, are heavily dependent upon the adequacy of Medicaid payments.

If State Medicaid rates are not "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" as required by the federal Medicaid statute, an action in federal court is the only remedy for these hospitals. Federal administrative review of State Medicaid rates is perfunctory. States need not permit hospitals to challenge the State's own compliance with federal law as part of State administrative remedies.

Inner city hospitals cannot continue to operate without participating in the Medicaid program. If Medicaid payments are inadequate, the hospitals' only solutions are to close or declare bankruptcy.

Congress required that State Medicaid payments be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." While that standard gives States greater latitude in setting rates than prior law, it also imposes limitations which Congress intended to be met to assure quality care for Medicaid patients. An action by hospitals in federal court is the appropriate enforcement mechanism.

ARGUMENT

1. A FEDERAL COURT LAWSUIT IS A HOSPITAL'S ONLY REMEDY FOR INADEQUATE MEDICAID PAYMENT RATES.

Neither review of state Medicaid plans by the federal Department of Health and Human Services nor state administrative procedures afford Medicaid providers an adequate remedy for legally insufficient Medicaid payment rates.

A. The Secretary of Health and Human Services Does Not Review the Adequacy of Medicaid Rates.

The federal Medicaid regulations require states participating in the Medicaid program to submit Medical Assistance Plans to the Secretary of Health and Human Services and to give annual assurances and make findings that the rates are "reasonable and adequate". The Secretary, however, believes that the Medicaid statute "does not require him to analyze or verify the State's findings, but only to satisfy himself that there is a reasonable basis on which the State's assurances may be accepted." Brief of Amicus United States at 21.

In actual practice the Secretary undertakes no review at all. An HHS official has testified in Pennsylvania that HHS practice is not to "look behind" the assurances given by any State. *See* Testimony of Peter Goodman, cited in support of Finding 201 of the District Court in *West Virginia University Hospitals, Inc. v. Casey*, 701 F. Supp. 496, 510 (M.D. Pa. 1988). Possible review by the Secretary of HHS does not provide hospitals with an effective remedy for inadequate payment rates.

B. State Administrative Procedures Do Not Provide Hospitals With a Remedy for Inadequate Medicaid Rates.

Federal regulations require participating States to institute an appeals procedure by which providers can challenge their payment rates:

> *Provider appeals.* The Medicaid agency must provide an appeals or exception procedure that allows individual providers an opportunity to submit additonal evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates.

42 C.F.R. § 447.253(c)(1987). The State Medicaid agency can determine what issues are appropriate for review and need not include as such an issue the compliance of its rate system with the federal Medicaid statute. The State Medicaid agency is not even required to permit judicial review of its determination of any appeal. 48 Fed. Reg. 56,046, 56,052 (December 19, 1983). Appeals or exceptions under this regulation, therefore, do not afford providers with a remedy to redress a State's failure to comply with the federal Medicaid statute.

II. AN INNER CITY HOSPITAL CANNOT WITHDRAW FROM THE MEDICAID PROGRAM.

If Medicaid payments are inadequate for their needs, the inner city hospitals who bear the principal burden of providing medical care to the indigent cannot withdraw from the Medicaid program.

Amici States of Connecticut et al., at pages 2-3, argue that health care providers are not the intended beneficiaries of the Medicaid program but are business entities that have made the voluntary business decision to enter the Medicaid program, much like the construction companies that build elementary schools. The amici argue that, if a health care provider is dissatisfied with Medicaid rates, his remedy is to withdraw from the program. This argument ignores the locations as well as the legal and social obligations of inner city hospitals that provide the largest portion of Medicaid services.

To begin with, many inner city hospitals have received Hill-Burton funds. Regulations promulgated in 1979 by the Secretary of Health and Human Services require any hospital that has ever received federal construction assistance under the Hill-Burton program to participate in the medicaid program. 42 C.F.R. § 124.603(c)(1)(ii) (1979). Federal courts have upheld the application of this requirement even to those hospitals that received construction assistance prior to its promulgation. *American Hospital Association v. Schweiker,* 529 F. Supp. 1283 (N.D. Ill. 1982), *aff'd,* 721 F.2d 170 (7th Cir. 1983), *cert. denied,* 466 U.S. 958 (1984). Thus, no inner city hospital which has received Hill-Burton funds could exercise the option to withdraw from the Medicaid program even if there were no other restrictions.

Even if they have never received Hill-Burton funds, hospitals cannot choose not to participate in the Medicaid program the way that construction companies can decline to build schools. Construction companies have mobile equipment and personnel which move from jobsite to jobsite. In contrast, hospitals provide services from fixed locations and draw patients from the sur-

rounding neighborhoods. As a result, the burden of Medicaid patients is unevenly distributed. Rural and suburban hospitals typically serve relatively small numbers of Medicaid patients; inner city hospitals serve large numbers.[7]

Serving Medicaid patients is not only the regular function of inner city hospitals; in many cases it is legally required. Regulations of the Pennsylvania Department of Health require a hospital to provide emergency room services consistent with the scope of that hospital's services. 28 Pa. Code §§ 117.12, 117.13 (1981). Police and fire departments bring large numbers of patients to hospital emergency rooms. Under both federal and state law, a hospital must accept and treat any patient who needs emergency treatment.[8] Thus, as a result of federal and state law and municipal practiee, inner city hospitals receive large numbers of indigent patients whom they are required to treat. If an inner city hospital withdrew from the Medicaid program, it

[7]The average hospital in Pennsylvania had 13% Medicaid occupancy in 1986-1987. Nine hospitals were more than two standard deviations above that statewide mean. Eight of those hospitals, with Medicaid occupancy percentages of up to 85%, serve North Philadelphia; the ninth serves a largely indigent black neighborhood in West Philadelphia. Similarly, the average Pennsylvania hospital had 7194 Medicaid inpatient days. Seven hospitals, all in Philadelphia, had more than 40,000 such days and provided over 19% of the care given by 229 general hospitals.

[8]Federal law requires any hospital which has an emergency room and participates in the Medicare program to accept any patient with an emergency medical condition or in active labor, and to screen and stabilize that patient before transferring him or her to another facility. 42 U.S.C. § 1395dd (Supp. V 1987) Pennsylvania state regulations include a similar requirement. 28 Pa. Code § 117.13 (1981).

would be compelled to treat large numbers of patients without any compensation whatsoever.[9]

These legal requirements reflect the expectation of society that non-profit charitable hospitals are not business entities but service organizations for the communities in which they are located. An inner city hospital can attempt to expand its market and to draw patients from beyond its immediate neighborhood for specialized treatments for which it has particular capabilities.[10] Treatment of these patients may generate surplus revenues which can be used to partially offset losses from the treatment of indigent patients. However, an inner city hospital cannot remain open while turning its back on the community in which it is located. Regardless of legal requirements, the community would not permit the hospital to refuse to treat indigent patients.

In summary, an inner city hospital that cannot survive on the payments it receives under the Medicaid program (and whatever other sources of revenue it may have) cannot withdraw and serve a different patient population. If Medicaid payments are insufficient, the hospital can only declare bankruptcy or close.[11]

[9]Many of these emergency room admissions are not eligible for Medicaid but are still unable to pay for hospital care. Inner city hospitals care for these patients without any payment.

[10]The ability of a hospital to do this would be limited, in many states, by its ability to obtain approval under certificate of need laws for capital expenditures and additional services.

[11]In the last two years, three hospitals serving North Philadelphia have filed for protection under the federal bankruptcy laws. Three more, including Temple University Hospital, are in serious financial difficulty. If Temple University Hospital were to close, there would be a serious shortage of hospital services in North Philadelphia. As recently as November 28, 1989, a hospital in South Philadelphia announced that it was closing because of inadequate Medicaid and Medicare payments.

III. A FEDERAL CAUSE OF ACTION FOR HOSPITALS IS NECESSARY TO ACHIEVE THE CONGRESSIONAL PURPOSE

In requiring that Medicaid payments be "reasonable and adequate" to meet hospital costs, Congress gave both freedom and direction to the States. On the one hand Congress intended to give significant discretion to States in setting payment rates. The Courts have responded by holding that the "reasonable and adequate" standard is not a precise number but a range. *West Virginia University Hospitals, Inc. v. Casey*, 885 F.2d 11, 26 (3d Cir. 1989); *Colorado Health Care Association v. Colorado Department of Social Services*, 842 F.2d 1158, 1167 (10th Cir. 1988); *Wisconsin Hospital Association v. Reivitz*, 733 F. 2d. 1226, 1233 (7th Cir. 1984). The Courts have not engaged in an independent determination of what the Medicaid rates should be and have declared them not to be "reasonable and adequate" to meet hospital costs only if they were arbitrary and capricious. *West Virginia University Hospitals, Inc. v. Casey*, 885 F. 2d 11, 24 (3d Cir. 1989); *Mississippi Hospital Association v. Heckler*, 701 F. 2d 511, 516 (5th Cir. 1983).

On the other hand, Congress did not intend to give States a license to do whatever they pleased. Congress was clear that a State should not "develop rates ... solely on the basis of budgetary appropriations." H.R. Conf. Rep. No. 1479, 96th Cong., 2d Sess. at 154, *reprinted in* 1980 U.S. Code Cong. & Ad. News 5944. The Senate stressed that "[t]he flexibility given the States is not intended to encourage arbitrary reductions in payments that would adversely affect the quality of

care." S. Rep. No. 139, 97th Cong., 1st Sess. at 478, *reprinted in* 1981 U.S. Code Cong. & Ad. News 744. As the Secretary of Health and Human Services has stated as to nursing homes:

> If facilities are underpaid, because a State's flat rate is unrealistically low or because in determining its rate, the State refuses to recognize as allowable costs some of the real costs of providing services, facilities will be under pressure to cut corners and provide lower quality care or will be forced to make their non-medicaid patients absorb some of the costs of Medicaid patients' care; at worst, facilities may refuse to accept Medicaid patients.

41 Fed. Reg. 27,300 (July 1, 1976).

If Medicaid rates are not "reasonable and adequate" to pay hospital costs, the inner city hospitals that treat the largest portion of the Medicaid patients cannot make up the difference by charging more to non-medicaid patients. Nor can they refuse to admit Medicaid patients. They can only cut corners, reduce services, and incur losses. If Medicaid patients are to receive quality care, as Congress intended, these inner city hospitals must have an effective remedy. The hospitals are immediately and directly affected by the inadequacy of State Medicaid rates to pay hospital costs.

Patients are not immediately and directly affected by violation of this requirement. They have no knowledge of hospital costs, Medicaid payment rates, or, in many cases, hospital standards of care. Federal regulations require that the hospital send the bill to the State, accept the Medicaid payment as payment in full, and not seek additional payment from the patient. 42

C.F.R. § 447.15 (1985). As a result, patients are admitted, treated, and discharged without knowing how much the hospital is paid for their treatment. Patients cannot be expected to enforce a legal requirement when they are not privy to the facts which would cause the requirement not to be met.

The federal Medicaid statute requires that rates be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." Only if that requirement is met can Medicaid recipients, particularly those in inner city neighborhoods like those surrounding Temple University Hospital, receive the quality of care that Congress intended and that their critical health needs require.

State governments understandably want to minimize their expenditures. If the Congressional purpose of assuring quality care to Medicaid recipients is to be achieved, decisions by those governments on what rates are "reasonable and adequate" must be subject to impartial review at the behest of those entities most immediately and directly affected. This can only be accomplished through an action by a provider in federal court. Because of the latitude inherent in the "reasonable and adequate" standard, and the deference given by Courts to the State rate-setting decisions, providers should be expected to sue only in extreme circumstances and States which have acted responsibly should have little to fear.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

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